

Registration District No. 1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County MO
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days)

8. (a) PRINT FULL NAME HELEN MASON BURNS 659

8. (b) If veteran, name war. 8. (c) Social Security No.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife HARRIS E. BURNES
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased DEC 7 1892
(Month) (Day) (Year)

8. AGE: Years 46 Months 11 Days 4 If less than one day
hr. min.

9. Birthplace ARK. (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

12. Name JOSEPH MASON

13. Birthplace IND. (City, town, or county) (State or foreign country)

14. Maiden name NORA MALONEY

15. Birthplace IND. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harris E. Burns

(b) Address 400 GOLD DR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-14-1939 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director P. M. Muller

(b) Address 5765 DELMAR BLVD.

19. (a) NOV 13 1939 (Date received local registrar) (b) J. P. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 7046 Mansfield NR
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1939 hour 4-45 minute P M.

21. I hereby certify that I attended the deceased from 11-8, 1939, to 11-11, 1939; that I last saw her alive on 11-11, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death
CEREBRAL HEMORRHAGE
ANURIA
Due to HYPERTENSIVE CARDIOVASC DISEASE
Duration 4 da
2 da
indefinite

Due to
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury
23. Signature Henry Hoffner (M. D. or other) MD
Address BARNES HOSPITAL Date signed 11-11-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Howard H. Howland*

Licensed Embalmer No. *3114*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.